

MARYLAND STATE DEPARTMENT OF HEALTH
 BUREAU OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

2008

CERTIFICATE OF DEATH

01984

1. PLACE OF DEATH o. COUNTY		Kent MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) o. STATE		Maryland					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chestertown		c. LENGTH OF STAY IN lb life		b. COUNTY		Kent					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Water St.				d. STREET ADDRESS		Chestertown Water St.					
3. NAME OF DECEASED (Type or print)		First James	Middle Lambert	Last Bacchus	4. DATE OF DEATH	Feb. 8.	Month 1961	Day 19	Year		
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Jan. 22, 1894		9. AGE (In years last birthday) 67 yrs.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Antique Dealer		10b. KIND OF BUSINESS OR INDUSTRY owner		11. BIRTHPLACE (State or foreign country) Kent Co. Maryland		12. CITIZEN OF WHAT COUNTRY? USA					
13. FATHER'S NAME Jefferson D. Bacchus		14. MOTHER'S MAIDEN NAME Lousia Lambert				Address Ethel Bacchus Melamet					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes		16. SOCIAL SECURITY NO. WW 1		17. INFORMANT		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic cancer lung 180 Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) with skin metastases) DUE TO Cancer of left kidney (renal cell ca of kidney DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 6 months			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from November 1960, to February 8, 1961, that (I) (we) last saw the deceased alive on 2-7-1961, and that death occurred at 10 A.M. from the causes and on the date stated above.											
22a. SIGNATURE A. C. Dick		22b. DATE 2/9/61		22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS Chestertown, Md.					
23a BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 2/10/61		23c. NAME OF CEMETERY, OR CEMETORY Chester Cemetery		23d. LOCATION (City, town, or county) Chestertown, Maryland					
24. FUNERAL DIRECTOR'S SIGNATURE J. Willis Wells		ADDRESS Chestertown, Md.		25a. REC'D BY REGISTRAR DATE FEB 14 '61		25b. REGISTRAR'S SIGNATURE Clinton S. Thomas					

2005

1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death, if any
please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page
4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health,
or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

01985

2009

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH
a. COUNTY

Kent

MARYLAND

b. CITY OR TOWN (if outside corporate limits,
write RURAL and give nearest town)

Chestertown

c. LENGTH OF STAY IN 1b

18 hours

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

Kent & Queen Annes

3. NAME OF
DECEASED
(Type or print)

GEORGE LEONARD COFFMAN

4. SEX
Male

6. COLOR OR RACE
White

7. MARRIED NEVER MARRIED

8. DATE OF BIRTH

WIDOWED DIVORCED

Lesl

4. DATE
OF
DEATH

February 28

1961

10a. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

10b. FATHER'S NAME
Earl G. Coffman

10b. KIND OF BUSINESS OR INDUSTRY
Farm

11. BIRTHPLACE (State or foreign country)
Maryland

12. CITIZEN OF WHAT COUNTRY?
USA

15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT

(Yes, no, or unknown) (If yes give rank or grade of service)

216 49 4116

Ethel Turner
Earl Coffman, Marydel, Md.

Address

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Extensive electrical burns (high voltage)

835 X
Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause last.

DUE TO

involving left arm and leg, lumbar area of 19 hours

(b) back, and also to a lesser degree the right arm & leg

DUE TO

(c)

INTERVAL BETWEEN
ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)

19. WAS AUTOPSY
PERFORMED?

YES NO

20a. EXTERNAL CAUSE WAS
PRIMARY OR CONTRIBUTING 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
cause of death. drove a tractor into a pole and caused hi-tension wires

to fall, catching under tractor and preventing his removal
20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, farm, 20f. (City or town)
Hour X. at work at work (County) (State)
3:15 p.m. 2/27/61 19 for about 15 minutes. Current did not stop/
at work at work farm near Millington, Md, Kent

21. I certify that I took charge of the remains described above, held an Autopsy Inspection Inquiry and in my opinion
death resulted from: Natural causes Accident Suicide Homicide Undetermined manner

ACTUAL
SIGNATURE *Robert W. Farr*

CHIEF MEDICAL EXAMINER

M.D. ASSISTANT MEDICAL EXAMINER

DEPUTY MEDICAL EXAMINER

DATE SIGNED

2/28/61

Address (Street, city, town, or county) *Chestertown, Kent, Md.*

22a. BURIAL, CREMATION,
REMOVAL (Specify) 22b. DATE THEREOF 22c. NAME OF CEMETERY OR CREMATORIAL
Burial 3/2/61 *Holmes Cemetery* 22d. LOCATION (City, town, or country) (State)
Burial Sudlersville *Md.*

23. FUNERAL DIRECTOR ADDRESS 24a. REC'D BY REGISTRAR 24b. REGISTRAR'S SIGNATURE

Edward Eller Millington Md. DATE MAR 3 '61 *Arthur S. Knue*

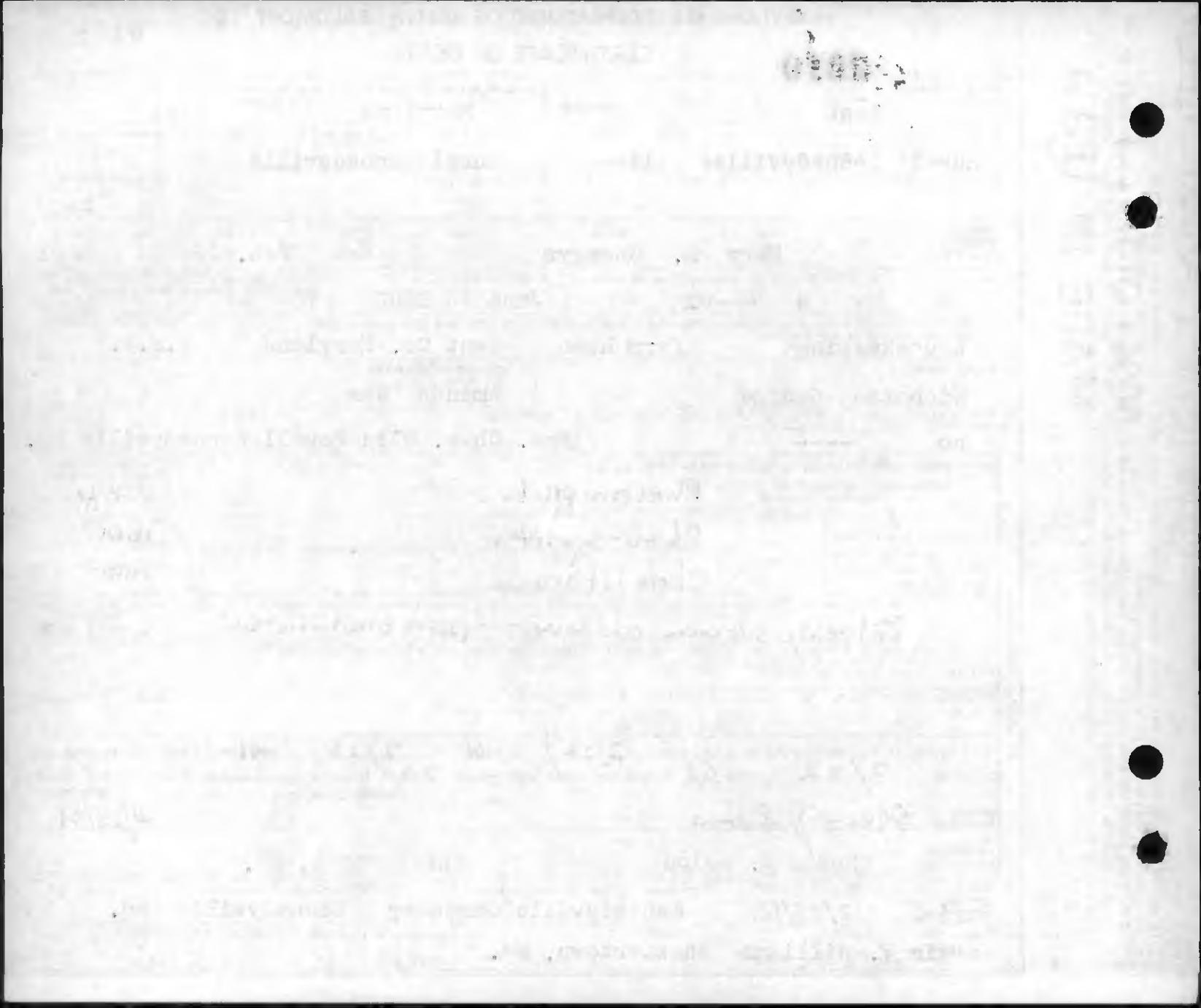
M

I

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
2010 CERTIFICATE OF DEATH

Reg. Dist. No. 01980

1. PLACE OF DEATH a. COUNTY Kent		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Kennedyville		b. COUNTY Kent	
c. LENGTH OF STAY IN 1b Life		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Kennedyville	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) Mary E. Comegys		4. DATE OF DEATH Feb. 22	Month Day Year 19 61
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 20 1882
9. AGE (In years last birthday) 78 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housekeeping	
11. BIRTHPLACE (State or foreign country) Kent Co. Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Nicholas George		14. MOTHER'S MAIDEN NAME Amanda Cox	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. INFORMANT Mrs. Chas. Olin Powell Kennedyville Md.	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 584		2 days	
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO		1 MDF	
(c) DUE TO		1 MDF	
(c) DUE TO		Cholelithiasis	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Palpable Nodules on liver - possible metastatic - Ca		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 2/22/61 , to 2/23/61 , that I last saw the deceased alive on 2/22/61 , and that death occurred at 7 A.M. from the causes and on the date stated above.		ADDRESS (Street, city or town, state) Chrstertown, Md. DATE SIGNED 2/25/61	
ACTUAL SIGNATURE Thomas J. Solon		M.D.	
PHYSICIAN'S NAME (Type) Thomas J. Solon		Chrstertown, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2/25/61	
22c. NAME OF CEMETERY OR CREMATORIUM Kennedyville Cemetery		22d. LOCATION (City, town, or county) Kennedyville Md. (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Marvin V. Williams		ADDRESS Chestertown, Md.	
24a. REC'D BY REGISTRAR FEB 27 '61		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate in the word "pending" in pencil in Item 18. Give Page 1, 2, and 3 to the funeral director. Page 5 may be retained for your information.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 2011												Reg. Dist. No. 01987					
1. PLACE OF DEATH a. COUNTY Kent MARYLAND						2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Delaware b. COUNTY Sussex											
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) near Kennedyville			c. LENGTH OF STAY IN lb Short			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Delmar 46X-1			d. STREET ADDRESS 606 Jewell St			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Railroad Eng. Accident (Penna. RR)						4. DATE OF DEATH Feb. 5, 1961											
3. NAME OF DECEASED (Type or print)		First Joseph	Middle Carlas	Last Dickerson	Month	Day	Year	5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH 10/4/1918	9. AGE (in years last birthday) 42 yrs.	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days	12. IF UNDER 24 HRS. Hours	13. IF UNDER 24 HRS. Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Penna. R. R. Engineer						10b. KIND OF BUSINESS OR INDUSTRY						11. BIRTHPLACE (State or foreign country) Delaware					
12. CITIZEN OF WHAT COUNTRY? USA																	
13. FATHER'S NAME Edward Dickerson						14. MOTHER'S MAIDEN NAME Amanda Givens											
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes						16. SOCIAL SECURITY NO. 717-12-5143						17. INFORMANT Address Geraldine Dickerson, Delmar, Del.					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]												INTERVAL BETWEEN ONSET AND DEATH immediate					
PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) Crushing injuries to chest & abdomen																	
800 DUE TO Conditions, if any, which gave rise to immediate cause (b)																	
(a), stating the underlying cause lost. DUE TO (c)																	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.) was crushed as result of RR. derailment											
20c. TIME OF INJURY Hour 8:30 p.m.			Month, Day, Year 2/5/61 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Railroad			(County)		(State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .																	
ACTUAL SIGNATURE Robert W. Farr						M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>						DATE SIGNED 2/6/61					
EXAMINER'S NAME (Type)						ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>											
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>																	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial			22b. DATE THEREOF 2-9-61			22c. NAME OF CEMETERY OR CREMATORIAL Mt. Olive			22d. LOCATION (City, town, or county) Delmar, Del.			(State)					
23. FUNERAL DIRECTOR'S SIGNATURE W. W. Marshall Co - Delmar, Del.						ADDRESS											
24a. REC'D BY REGISTRAR FEB 8 '61 DATE						24b. REGISTRAR'S SIGNATURE Arthur S. Koenig											
VS. AISM(E5) SM 9/55																	

17. АВТОМАТИЧЕСКАЯ СИСТЕМА ДЛЯ ОБОРОНЫ
ПЛАСТОВОГО СВИДОВОГО СЫРЬЯ

СИСТЕМЫ



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

2012

CERTIFICATE OF DEATH

01988

1. PLACE OF DEATH a. COUNTY Dent MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Kent	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bettertown		c. LENGTH OF STAY IN 1b 21 years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION At Home		e. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) William Henry Fleckenschildt		4. DATE OF DEATH Feb. 16, 1961	Month Day Year Feb. 16, 1961
5. SEX male		6. COLOR OR RACE white	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH Aug. 13, 1888	
9. AGE (In years last birthday) 72 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Wholesale Meats	
11. BIRTHPLACE (State or foreign country) Baltimore City		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Henry Fleckenschildt		14. MOTHER'S M AIDEN NAME Margaret Boggs.	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 216-18-8700	
17. INFORMANT Mrs. Edgar Harris		Address Chestertown, Md. daughter	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) 1800 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) DUE TO (c) DUE TO (d)		Ventricular Fibrillation Old coronary artery disease	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH 1 month 10 years	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from July 1955 to 19, that (I) (we) last saw the deceased alive on Mar 8 1961, and that death occurred at 3 PM, from the causes and on the date stated above.		22b. DATE SIGNED 2/17/61	
22a. SIGNATURE Florence D. Joyce		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) Florence D. Joyce		22d. ADDRESS RFD Worton Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Feb. 20, 1961	
23c. NAME OF CEMETERY OR CREMATORIAL Chester Cemetery		23d. LOCATION (City, town, or county) (State) Chestertown, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE J. Willis Wells		ADDRESS Chestertown, Md.	
		25a. REC'D BY REGISTRAR FEB 23 '61	
		25b. REGISTRAR'S SIGNATURE Arthur S. Krause	

PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

ATTENDANT: may be retained by the physician or attending physician.

FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

01983

2013

1. PLACE OF DEATH a. COUNTY <u>Kent</u>		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>MARYLAND</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Lynch</u>		c. LENGTH OF STAY IN 1b <u>9 years</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>At Home</u>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Lynch</u>	
e. STREET ADDRESS <u>Minst. Main St.</u>		f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>William Webster Hadaway</u>		4. DATE OF DEATH Last <u>Feb. 27</u> , Month <u>1961</u> Day <u>19</u> Year	
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH <u>Dec. 14, 1890</u>	
WIDOWED <input type="checkbox"/>		DIVORCED <input type="checkbox"/>	
9. AGE (In years (at birthday) yrs.) <u>70</u>		10. IF UNDER 1 YEAR <input type="checkbox"/> IF UNDER 24 HRS Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Automobile Mechanic (laborer)</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Kent Co. Md.</u>	
10c. BIRTHPLACE (State or foreign country) <u>Kent Co. Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Daniel Hadaway</u>		14. MOTHER'S MAIDEN NAME <u>Alice Jones</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO <u>216-01-6062</u>	
17. INFORMANT <u>Mrs. Wm. Webster Hadaway</u>		Address <u>Lynch, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Intracranial hemorrhage</u>		INTERVAL BETWEEN ONSET AND DEATH <u>6 hrs 40 min</u>	
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b)			
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Hour <u>a. m.</u> <u>19</u>		20d. INJURY OCCURRED White <input type="checkbox"/> Nat white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <u>Chestertown</u> , (County) <u>St. Mary's Co.</u> (State) <u>Md.</u>	
21. I certify that (I) (this hospital) attended the deceased from <u>2/27</u> , 19 <u>61</u> to <u>2/27</u> , 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>2/27</u> , 19 <u>61</u> and that death occurred at <u>3:40 PM</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Robert W. Farr</u>		M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/> 22b. DATE <u>Feb. 28, 1961</u>	
22c. PHYSICIAN'S NAME (Type) <u>Robert W. Farr</u>		22d. ADDRESS <u>Chestertown, Md.</u>	
23a. BURIAL CREMATION, REASON (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Mar. 2, 1961</u>	
23c. NAME OF CEMETERY OR CREMATORIAL <u>Chestertown Cemetery</u>		23d. LOCATION (City, town, or county) <u>Chestertown, Md.</u> (State) <u>Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>J. Willis Wells</u>		ADDRESS <u>Chestertown, Md.</u>	
25a. REC'D BY REGISTRAR <u>MAR 2 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Krause</u>	

TO HOSPITAL **ATTENDANT** **PHYSICIAN**: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

2014 01990

1. PLACE OF DEATH a. COUNTY Kent		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chestertown		c. LENGTH OF STAY IN 1b one-half hr		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Kent & Queen Anne's Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)	First Minnie	Middle Phillips	4. DATE OF DEATH 2 Month Day Year 1 19 61	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 75 yrs	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY DELAWARE		
13. FATHER'S NAME UNKNOWN		14. MOTHER'S MAIDEN NAME UNKNOWN		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 219-14-2801	17. INFORMANT WM. LEARY Address Rock Hall Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Over Exposure to Weather 132.9 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION IN PART I(a)				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Rock Hall (County) Md. (State)
21. I certify that (I) (this hospital) attended the deceased from 2/1/61 to 2/1/61 , that (I) (we) last saw the deceased alive on 2/1/61 , and that death accrued at Rock Hall, Md. from the causes and on the date stated above.				22b. DATE SIGNED
22c. SIGNATURE Wm. W. Gatewood		M.D. <input type="checkbox"/> ATTENDING PHYSICIAN MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22d. ADDRESS Rock Hall, Md.	
23a. BURIAL, CREMATION OR REMOVAL (Specify) BURIAL	23b. DATE THEREOF 2/4/61	23c. NAME OF CEMETERY OR CREMATORIAL Wesley Chapel	23d. LOCATION (City, town, or county) Rock Hall (State) Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Edgar L. Lane Chapel Hill Md.	ADDRESS	25a. REC'D BY REGISTRAR DATE FEB 7 '61	25b. REGISTRAR'S SIGNATURE Arthur S. Thomas	



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

2015 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1103

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)	
Kent		b. STATE	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)		Maryland	
Chestertown		c. LENGTH OF STAY IN lb	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)		1 day	
Kent & Queen Annes		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print)		Sudlersville (rural)	
First Middle		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
4. SEX Male		f. DATE OF DEATH	
5. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	
10e. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		8. DATE OF BIRTH	
Laborer		10b. KIND OF BUSINESS OR INDUSTRY	
13. FATHER'S NAME		11. BIRTHPLACE (State or foreign country)	
John Spencer		12. CITIZEN OF WHAT COUNTRY?	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or date of service)		16. SOCIAL SECURITY NO.	
Yes Korean		17. INFORMANT	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]		Martha Wexx Beale Address	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Central nervous system damage DUE TO Conditions, if any, which gave rise to immediate cause (b) Carbon monoxide poisoning DUE TO (c) Was found in his one room home about 9:30 AM 2/20/61		Hospital Records, Chestertown, Md. INTERVAL BETWEEN ONSET AND DEATH 30 hours	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I & was brought to hospital in an unconscious state. Never regained consciousness and died in a terminal hyperpnea about 30 hrs later. A coal heater was discharging gass into the room.		30 hours 2/20/61 PERFORMED?	
20c. TIME OF INJURY Month, Day, Year		20d. INJURY OCCURRED	
20c. TIME OF INJURY Month, Day, Year		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20c. TIME OF INJURY Month, Day, Year		20f. (City or town) (County) (State)	
20c. TIME OF INJURY Month, Day, Year		20g. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		Sudlersville, Ga. Md.	
ACTUAL SIGNATURE		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type)		M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22e. BURIAL/CREMATION REMOVAL (Specify)		DATE SIGNED	
22f. FUNERAL DIRECTOR		22g. NAME OF CEMETERY OR CREMATORIAL ADDRESS	
Burial Feb. 23, 1961		22h. LOCATION (City, town, or country) (State)	
23. FUNERAL DIRECTOR		24e. REC'D BY REGISTRAR	
Edward Fellows, Wellington, Md.		24b. REGISTRAR'S SIGNATURE	
ADDRESS		DATE FEB 24 '61	
ADDRESS		Signature	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any of the following is needed, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PMA3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

8

X

22

7

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2016

CERTIFICATE OF DEATH

Reg. Dist. No. 0199

1. PLACE OF DEATH a. COUNTY Kent		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Kent		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) R. D. 1 Chestertown		c. LENGTH OF STAY IN 1b 44 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) R. D. 1. Chestertown		d. STREET ADDRESS -----		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION -----				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) Lydia		First	Middle	Last	4. DATE OF DEATH February 11	Month	Day	Year 1961
5. SEX Female		6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 28, 1895	9. AGE (In years last birthday) 65 yrs.	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days	12. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.		
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Unknown				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. ---		INFORMANT Ruth Whittington, Chestertown, Md.		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 331X DUE TO <i>Cerebral Vascular Accident</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO <i>Atherosclerosis, Hypertension</i> (c) DUE TO <i>Arterosclerosis Generalized</i> INTERVAL BETWEEN ONSET AND DEATH 1 hour years years.								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (d) <i>Congestive Heart Failure, 2 Previous Strokes</i> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
20a. ACCIDENT OR UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Hour o. m. p. m.		Month 19	Day 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Chestertown	(County) Md.	(State) Md.
21. I certify that I attended the deceased from <u>1/30</u> , 1958, to <u>1/21/61</u> , 1961, that I last saw the deceased alive on <u>1/31/61</u> , 1961, and that death occurred at <u>4:45 AM</u> , from the causes and on the date stated above.								
ACTUAL SIGNATURE <i>Thomas J. Solon</i>		ADDRESS (Street, city or town, state) Chestertown, Md. DATE SIGNED 2/11/61						
PHYSICIAN'S NAME (Type) Thomas J. Solon		Chestertown, Md.						
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2/14/28		22c. NAME OF CEMETERY OR CREMATORIUM Mt. Zion Cemetery		22d. LOCATION (City, town, or county) Still Pond, Md. (State)		
23. FUNERAL DIRECTOR'S SIGNATURE Victor N. Kennedy		ADDRESS Still Pond, Md.		24a. REC'D BY REGISTRAR 2/14/61		24b. REGISTRAR'S SIGNATURE William E. Krause		

1908

1912

1914

John Gould A. S. 1908 to Scotland 1914

M

X

I

O

B

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2017

CERTIFICATE OF DEATH

Reg. Dist. No. 01093

1. PLACE OF DEATH a. COUNTY Kent		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chestertown		c. LENGTH OF STAY IN 1b 4 mo.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Duyer Apts.		3. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chestertown	
4. NAME OF DECEASED (Type or print) Jennie Wilkins		d. STREET ADDRESS Duyer Apts. Mapel Ave.	
5. SEX F		6. COLOR OR RACE W	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>		8. DATE OF BIRTH Jan. 29 1873	
9. AGE (In years last birthday) 88 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housekeeping	
11. BIRTHPLACE (State or foreign country) Chestertown Kent Co. Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Edward Mifflin Wilkins		14. MOTHER'S MAIDEN NAME Mary Anna Merritt	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 410 X Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.		INFORMANT Miss Grace Wilkins Address Chestertown, Md.	
DUE TO (b) Mitral insufficiency		INTERVAL BETWEEN ONSET AND DEATH 3 days	
DUE TO (c) Old rheumatic heart disease ??		6 months	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 12-1, 1960, to 2-27, 1961, that I last saw the deceased alive on 2-26, 1961, and that death occurred at 3:40 a.m. from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>A. C. Dick</i>		ADDRESS (Street, city or town, state) M.D. DATE SIGNED 2-27-61	
PHYSICIAN'S NAME (Type) A. C. Dick		Chestertown, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Mar. 1/61	
22c. NAME OF CEMETERY OR CREMATORIAL Chester Cemetery		22d. LOCATION (City, town, or county) Chestertown, Md. (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Marvin V. Williams		ADDRESS Chestertown, Md.	
24a. REC'D BY REGISTRAR DATE MAR 6 '61		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Krause</i>	

